MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

07153

CERTIFICATE OF DEATH

★ Reg. Dist. No. 232

1. PLACE OF DEATH:

County: Prince Georges

City or town: Forestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Summers

Hospital, Institution, or street address where death occurred: Marlboro Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Adamstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Washington Earl Adams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1908

8. AGE: Years: 37 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Aquasco, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

MOTHER FATHER

12. Name: George Adams

13. Birthplace: Maryland

MOTHER

14. Maiden name: Missouri Gray

15. Birthplace: Maryland

16. Informant: Mrs. Elsie Sager

Address: Benedict, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7 (month) 30 (day) 45 (year)

Cemetery or crematory: St. Peters

Location: Waldorf, Charles Co. Md.

18. Funeral director: Ritchie Brothers

Address: Upper Marlboro, Md.

19. Jul 28 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage, shock	
Due to: Fracture of base of skull	
Due to:	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should ho charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followlog:

Accident, suicide, or homicide: accident Date of 7-26-45

Where did injury occur? Forestville (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where)? Marlboro Pike Rt 2

Means of injury: truck & automobile injured at work? no

23. SIGNATURE: Deputy medical Examiner M. D. or Other

Address: Forestville md Date signed: 7-26-45

VS A15 (T) (1) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

67154

★ Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? March 26, 1945 - July 13, 1945 3 months 17 days

Hospital, Institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or Institution? 3 mos. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 16 First Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Baden, Mr. Charles E.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife: Emily W. Baden

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 17, 1859

8. AGE: Years 86 | Months | Days 25 | If less than one day: 6 hrs. 5 min.

9. Birthplace: Westwood, Prince Georges County, Md. (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business:

FATHER — 12. Name: John Baden

13. Birthplace: Westwood, Prince Georges County, Md.

MOTHER — 14. Maiden name: Mary Townsend

15. Birthplace: Westwood, Prince Georges County, Md.

16. Informant: Leland Memorial Hospital Records

Address: 4408 Queensbury Rd. Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16 1945 (month) (day) (year)

Cemetery or crematory: Prince Geo Co

Location: Mayflower

18. Funeral director: Mitchell Bros

Address: Upper Marlboro Md

19. July 13 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1945, at 6 05 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26, 1945, to July 13, 1945

and that I last saw h.. alive on July 4 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hr.
Due to: arteriosclerosis	15 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W. E. Malin, M.D. M. D. or other

Address: ____ Date signed ____

Gms. 804 g

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-d)

CERTIFICATE OF DEATH

67155

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 year
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Berwyn Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4807 Kenilworth st
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Meta Z. Bickford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Gershom Bickford
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): Dec 22. 1870

8. AGE: Years 74 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Penna (Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: Robert Murphy
13. Birthplace: Pa
MOTHER 14. Maiden name: Katherine Lindsay
15. Birthplace: Pa
16. Informant: Gershom Bickford
Address: Berwyn Md
17. Burial, cremation, or removal. Which? transportation Date thereof: July 17, 1945 (month) (day) (year)
Cemetery or crematory: Philadelphia
Location: Penna
18. Funeral director: E. Gaeche sons
Address: Hyattsville Md
19. July 16 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1945 abd at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1945 to July 14 1945
and that I last saw h alive on July 13 1945

Immediate cause of death: Chronic Hepatocarditis — DURATION: Several years
Due to: Arteriosclerosis — DURATION: Several years
Due to: Senility — DURATION: Several years
Other conditions: —
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: W. Allen Gifford M. D. or other
Address: Berwyn Md Date signed: 7/14/1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 39-C

CERTIFICATE OF DEATH

67156

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Red Top Stables, Ager Rd. & Riggs Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Ellen Brady

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband ~~or wife~~: Herbert B. Brady

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1911

8. AGE: Years 34 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: George Mulloy

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Susie C. Cusick

15. Birthplace: Maryland

16. Informant: Samuel B. Milburn

Address

17. Burial (Burial, cremation, or removal. Which?)
Date thereof: July 31, 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln Cemetery

Location: 3201 - Bladensburg Rd. Md.

18. Funeral director: William J. Nalley

Address: 3200 - R.I. Ave. Mt. Rainier, Md.

19. July 31 1945 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945, at 8.49 p.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1945, to July 28 1945,
and that I last saw her alive on July 28 1945

	DURATION
Immediate cause of death: Myocarditis with / Cardiac failure	1 day
Due to: [illegible]	11 days
Due to: [illegible]	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other

Address: 4316 Gallatin St. Date signed: 7/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

07157

★ Reg. Dist. No. 233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Croome

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEceased:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Croome

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John E. Butler

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	widowed

6.(b) Name of husband or wife Julia A. Butler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 4, 1866

8. AGE:

Years	Months	Days	If less than one day
79	2	27	..... hrs. ..... min.

9. Birthplace J. B. Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name George W. Butler

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Butler

MOTHER 15. Birthplace Maryland

16. Informant Harrison Butler

Address Croome, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-4-45 (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Upper Marlboro, Md.

18. Funeral director Tolson Brothers

Address Upper Marlboro, Md.

19. July 3 1945 (Date rec'd by registrar) James B. Naylor Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1945, to July 1 1945

and that I last saw h... alive on June 17 1945

Immediate cause of death	DURATION
Coronary thrombosis	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE ..... M. D. or other

Address Forestville, Md. Date signed 7-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54-6)

07158

CERTIFICATE OF DEATH

Reg. Dist. No. 246

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Geo.
City or town Bruntwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 7 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pr. Geo
City or town Bruntwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4317 - 41 st.
(If rural, give LOCATION)
2.(a) Was veteran, name war

3. (a) FULL NAME Mary Cheppas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22 - 1938

8. AGE: Years	Months	Days	If less than one day
6	7	9	hrs. min.

9. Birthplace New York City
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name John Cheppas
13. Birthplace Greece

MOTHER
14. Maiden name Harriett Pampas
15. Birthplace Greece

16. Informant John Cheppas
Address 4317-41 st. Bruntwood, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-3-45 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Suitland, md
18. Funeral director Low Chambers Co.
Address Riverdale, md

19. 7/3 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 5 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Compression	
Due to Brain tumor (malignant. Pathol's Stalk tumor - craniopharyngioma)	
Due to Inv. transfrontal area.	
Duration: since August, 1942 approx.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner
M. D. or other
Address Upper Marlboro Date signed 7-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-D)

CERTIFICATE OF DEATH

07159

★ Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Pr. Geo.
City or town: Berwyn Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John B. Columbus

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaret O.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 9, 1860

8. AGE: Years	Months	Days	If less than one day
84	11	14	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Shoe Salesman
11. Industry or business:

FATHER
12. Name: Charles G. Columbus
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Annie Berry
15. Birthplace: Maryland

16. Informant: Mrs. Margaret O. Columbus
Address: 4805 Fox St. Berwyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25-1945 (month) (day) (year)
Cemetery or crematory: Glenwood Cem.
Location:
18. Funeral director: The J. F. Nevins Co.
Address: 2901 14th Street N.W.

19. July 24th 1945 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/23 1945, at 11.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (SAW) 7/22 1945, to 7/25 1945; and that I last saw him alive on 7/22 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 hrs.
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. F. Heath M.D.
M. D. or other
Address: 1833 Monroe NE Washington DC
Date signed: 7/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63-P

CERTIFICATE OF DEATH

07160

★ Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Hyattsville, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Mo 1 yr. 4 mons
Hospital, institution, or street address where death occurred:
Mother Jones Rest Home
How long in hospital or institution? 1 yr 4 mon

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Col. County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 724 3rd St. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Peter Cook

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	Widowed

6.(b) Name of husband or wife: Sofie ?
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10, 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68 YRS		3		

9. Birthplace: Philadelphia Penn (Town, county, and state)
10. Usual occupation: Retired Painter
11. Industry or business: —

FATHER
12. Name: Charles Cook
13. Birthplace: Philadelphia Penn

MOTHER
14. Maiden name: ?
15. Birthplace: unknown

16. Informant: Mrs Lillie May Burgess
Address: Riggs Road, Hyattsville Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof July 17. 1945 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Wash. D.C.

18. Funeral director: Kathleen Walters by Day
Address: 25 E Carroll St. N.W. Tak. Park D.C.

19. July 13 1945 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1945, at 2 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-28-45 1945 to 7-13 1945 and that I last saw h. alive on 7-12-45 1945

	DURATION
Immediate cause of death: Thrombosis	5 days
Due to: Arteriosclerosis	8 yrs.
Due to: Myocardial failure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John P. Clum M.D. M. D. or other
Address: Hyattsville Md Date signed 7-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07161

★ Reg. Diat. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, Institution, or street address where death occurred: In Pennsylvania Depot pond

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town East Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Cooksey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9 - 1934.

8. AGE:

Years	Months	Days	If less than one day
10	8	27	hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation School child

11. Industry or business

FATHER 12. Name John Cooksey

13. Birthplace Md.

MOTHER 14. Maiden name Virginia Cooksey

15. Birthplace Md.

16. Informant Mabel Cooksey

Address Upper Marlboro, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 6, 1945 (month) (day) (year)

Cemetery or crematory

Location Riverdale Md.

18. Funeral director St. St. Flanders Co.

Address Riverdale Md.

19. July 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Asphyxia	
Due to Drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 7-6-45

Where did injury occur? Upper Marlboro (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where)? In pond

Means of injury? Drowning Injured at work? No

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Forestville Md. Date signed 7-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07162

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Pr. Georges
City or town: Cap. Hgts
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Georges
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6101 A St. Cap. Hgts
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Margaret Courtney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: Irving E.
6.(c) If alive, give age: Nov. 23 years
7. Birth date of deceased (mo., day, yr.): Nov. 23, 1884

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation:
11. Industry or business: Housewife
FATHER 12. Name: George L. Ballard
13. Birthplace: New Hampshire
MOTHER 14. Maiden name: Barbara A. Smith
15. Birthplace: Baltimore Md.
16. Informant: Irving E. Courtney
Address: 6101 A st. Cap. Hgts
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18 1945 (month) (day) (year)
Cemetery or crematory: Kenwood
Location: Wash. D.C.
18. Funeral director: W. W. Chambers Co.
Address: 517-11-st. S.E.
19. July 16 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945, at 6:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1945, to July 15 1945
and that I last saw h.. alive on July 15 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hours
Due to: Generalized arteriosclerosis & hypertension	10 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Brannin M.D.
M. D. or other
Address: Capitol Hgts, Md. Date signed 7/15/45

at 6700

DAY OF BIRTH of deceased: letter from GASCH, funeral director, filmed G97 8-31-45 L.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

67163

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:
County: Prince George
City or town: 4805 College Ave College Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Geo
City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4805 College Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Myron Creese

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen J. Creese
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 27th 1883

8. AGE: Years 62 | Months 0 | Days 4 | If less than one day: ..... hrs. 6s min.

9. Birthplace: Red Rock Pa
(Town, county, and state)

10. Usual occupation: Professor Electrical

11. Industry or business: Engineer U of Md

FATHER
12. Name: Samuel Creese
13. Birthplace: Pa

MOTHER
14. Maiden name: Millie Dempsey
15. Birthplace: Pa

18. Informant: Mrs Myron Creese
Address: College Park

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 31 1945 (month) (day) (year)
Cemetery or crematory: Russian City
Location: Penna

18. Funeral director: F Gaschis Sons
Address: Hyattsville Md

19. July 31st 1945 (Date rec'd by registrar) Johns D Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1945 at 1230 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945, to July 30 1945
and that I last saw h[illegible] alive on July 30 (noon) 1945

Immediate cause of death	DURATION
Coronary Thrombosis	30 Min.
Due to: Arterio-sclerosis	4 yrs +
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M D Etienne M.D.
M. D. or other
Address: Dercoyn Date signed 7/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

07164

CERTIFICATE OF DEATH ★

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince Georges
City or town Suitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince Geo
City or town Suitland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 Brown St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARIE C. ROMEN

3.(b) Social Security Number

4. Sex F | 5. Color or race W | 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 23 38

8. AGE: Years 87 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Hungary (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Geo Bondech

13. Birthplace Hungary

MOTHER 14. Maiden name Schmidt

15. Birthplace Hungary

16. Informant Carl Romen Address 29- Grant Rd. Suitland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3 45 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland Md

18. Funeral director L. L. Spencer Sr

Address 517-11 St SE

19. July 2 19 45 (Date rec'd by registrar) Carrie Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 45, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 45 to July 2 19 45 and that I last saw her alive on July 1 19 45

	DURATION
Immediate cause of death Cerebral Hemorrhage	12 hrs
Due to General Arterio Sclerosis	
Due to	
Other conditions none noted	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jane E Van Natta M. D.

Address Washington D.C. Date signed July 2 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47d

CERTIFICATE OF DEATH

07165

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 days

Hospital, institution, or street address where death occurred: Eugene Leland Memorial Hospital

How long in hospital or institution? 48 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Riverdale Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4615 Wells Parkway, Riverdale Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roy Stover Cross

3.(b) Social Security Number 217-05-2926

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Margaret Brown Gross 6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) December 15, 1885

8. AGE: Years 59 | Months 7 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace Virginia.
(Town, county, and state)

10. Usual occupation none.

11. Industry or business

FATHER 12. Name Joseph Franklin Cross

13. Birthplace Virginia.

MOTHER 14. Maiden name Rebecca Ann Stover

15. Birthplace Virginia.

16. Informant Patient's chart

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24, 1945 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cemetery

Location Colmar Manor, Md.

18. Funeral director Chambers.

Address Riverdale, Md.

19. July 24 1945 James Seevers
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at 1:50 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to July 22 1945

and that I last saw him alive on July 21 1945

Immediate cause of death: Bronchiogenic Carcinoma with Emphysema — DURATION: 2 yrs 6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Cancer collapsed R. lung

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Maher M.D.
M. D. or other

Address Riverdale, Md Date signed 7-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

67165

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Geo. Co.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days.
Hospital, institution, or street address where death occurred: Prince Geo. Gen. Hosp. Cheverly Md.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: P. G. Co.
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No. 3733 Wells Ave or Rainier Md. (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Dillon. Miss Minnie L.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec 23 1870 (Dec. 23, 1870)

8. AGE: Years	Months	Days	If less than one day
74	7	1	hrs. min.

9. Birthplace: Lynchburg Campbell Co. Va. (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Henry Clay Dillon
13. Birthplace: Franklin Co. Va.

MOTHER
14. Maiden name: Lucy ann akers
15. Birthplace: Lynchburg Campbell Co. Va.

16. Informant: Mrs Lillie B Earnest
Address: 3733 Wells Ave Mt Rainier Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 25 1945 (month) (day) (year)
Cemetery or crematory: Dunguid Funeral Home
Location: Lynchburg, Va.
18. Funeral director: F. Gadabois Sons
Address: Hyattsville md

19. 7/28 (Date rec'd by registrar) 1945 Amanda Deimer Registrar

MEDICAL CERTIFICATION

32

20. DATE OF DEATH: July 24 1945 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1945, to July 24 1945 and that I last saw her alive on July 24 1945

Immediate cause of death	DURATION
Carcinoma	1 1/2 yrs.
Origin ?	
Due to: Primary carcinoma of transverse colon.	
Due to: C.V.D.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Donald D Mitchell MD (M. D. or other)
Address: 1746 K St NW Wash DC Date signed: 7/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

CERTIFICATE OF DEATH

07167

★ Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? March 1 1945
Hospital, Institution, or street address where death occurred:
—
How long in hospital or institution? — none —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 703 Foote St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Thelma Katherine Elgin

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	married

6.(b) Name of husband or wife: Gus Elgin
6.(c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): April 8 1907

8. AGE: Years	Months	Days	If less than one day
38	4	21	... hrs. ... min.

9. Birthplace: Capitol Heights Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home
FATHER 12. Name: ~~Frank Turnbaugh~~
13. Birthplace: Geo. K. Stine — Wisconsin
MOTHER 14. Maiden name: Mary Turnbaugh
15. Birthplace: Washington DC
16. Informant: George N. Stine
Address: Seat Pleasant Md
17. Burial, cremation, or removal. Which? Burial Date thereof: August 6, 1945 (month) (day) (year)
Cemetery or crematory: Washington National Cemetery
Location: Pr. George Co. Maryland
18. Funeral director: James E. Ryan, Inc.
Address: 317 Penna. Ave. S.E. DC
19. 7-30 1945 (Date rec'd by registrar) Thos. E. Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1945 at 7:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1943 to July 29 1945 and that I last saw her alive on July 29 1945
Immediate cause of death: Carcinomatosis of Cervix with metastasis — DURATION: 2 yr
Due to: —
Due to:
Other conditions: none
(Include pregnancy within 3 months of death)
Major findings of operations: — none — Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul Van Tuyl M. D. or other
Address: 5440 Silver Hill Road Washington 19 DC Date signed: July 29 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ 67168

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georg's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Kenyon St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN EPPS

3.(b) Social Security Number: 519-18-1521

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Julia Epps

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): June 25, 1891

8. AGE: Years	Months	Days	If less than one day
54	-	6	...hrs. ...min.

9. Birthplace: Newburry, South Carolina
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Jim Epps
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Dorothy Abramson
15. Birthplace: South Carolina

16. Informant: Decedent

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-2-45 (month) (day) (year)

Cemetery or crematory:

Location: Removed to Washington D.C.

18. Funeral director: Wm T Tolbert

Address: 1908-6th N.W.

19. July 1, 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1945, at 5-40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6/27/1945 to 7/1/1945 and that I last saw h. /M. alive on 7/1/1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 MO
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 7/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

07169

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 7 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1907 Penn. Ave. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FRANK FELDER

3.(b) Social Security Number: 579-24-0745

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (sep.)

6.(b) Name of husband or wife: Narvies Felder
6.(c) If alive, give age: ?

7. Birth date of deceased (mo., day, yr.): April 15, 1901

8. AGE: Years	Months	Days	If less than one day
44	3	4	...hrs. ...min.

9. Birthplace: Orangeburg, South Carolina
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER
12. Name: Jim Felder
13. Birthplace: Orangeburg, S. Carolina

MOTHER
14. Maiden name: Ella Stroman
15. Birthplace: Orangeburg, S. Carolina

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal to Date thereof: July 20, 1945 (month) (day) (year)

Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: St. Joseph's Funeral Home
Address: 306 L. St. N.W., Wash. D.C.

19. (Date rec'd by registrar) July 19 1945 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1945, at 12.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1945 to July 19 1945 and that I last saw him alive on July 19 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mo.
Due to: Tuberculous enteritis	1 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ...Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, md Date signed: 7/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

07179 231

★ Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Chantilly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19½ hours

Hospital, institution, or street address where death occurred: Prince Georges Genl Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt Rainier (If outside city or town limits, write RURAL and give nearest town)

Street No. 4511-30th Street (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Margaret Felter

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Oscar C Felter

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 5, 1876

8. AGE: Years	Months	Days	If less than one day
69	5	21	hrs. min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Housemaid

11. Industry or business: Private Home

FATHER 12. Name: Edward Cheldren

FATHER 13. Birthplace: Baltimore, Md

MOTHER 14. Maiden name: Mary Jane Cassel

MOTHER 15. Birthplace: Maldon

16. Informant: Oscar C. Felter

Address: Mt. Rainier, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Colmar Manor Md

18. Funeral director: L. Gasch & sons

Address: Bladensburg Md.

19. 7/30 19 45 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 45, at 10 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~7/26/45~~ 19 45, to ~~7/27~~ 19 45

and that I last saw h.er alive on ~~7/27~~ 19 .

Immediate cause of death: Intra cranial Hemorage — DURATION

Due to: Cardio vascular disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: autopsy performed Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Forestville Md Date signed 7-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (138)

CERTIFICATE OF DEATH

07171

★ Reg. Diat. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 5 mos., 7 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 yr., 5 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2517 K. St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Elizabeth Fones

3.(b) Social Security Number: 578-09-6084

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry H. Fones

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 10, 1881

8. AGE: Years	Months	Days	If less than one day
63	11	22	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Agustus I. Powell
13. Birthplace: Georgia

MOTHER
14. Maiden name: Rebecca C. Sober
15. Birthplace: Prince George's Co., Maryland

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/3/45 (month) (day) (year)

Cemetery or crematory:

Location: Wash., D. C.

18. Funeral director: A. H. Hines Co.

Address: 2901-14th St. N.W.

19. June 2, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-2 19 45, at 5 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-25 19 44 to 7-2 19 45

and that I last saw her alive on 7-2 19 45

	DURATION
Immediate cause of death: Pulmonary tuberculosis	5½ yrs
Due to:	
Due to:	
Other conditions: Tuberculous laryngitis	5½ yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 7-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

07172

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred: Prince George Gen. Hosp
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 7497 Blair Road (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Baby boy Fritts (Newborn)
3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: ~~no~~
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 10 | If less than one day: hrs. min.

9. Birthplace: Prince George Gen Hosp Cheverly Md (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: John Fritts
FATHER 13. Birthplace:
MOTHER 14. Maiden name: Myra Mayes
MOTHER 15. Birthplace: Texas
16. Informant (Father) John Fritts
Address: 7497 Blair Rd Wash. D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8. 1945 (month) (day) (year)
Cemetery or crematory: Ft Lincoln
Location: Colmar Manor Md
18. Funeral director: F Gaschi sons
Address: Hyattsville Md
19. 7/3 19 45 Amanda Denney (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1, 1945, at 6 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Pulmonary hemorrhage	1 dy.
due to Purulent Bronchitis	12 dys.
due to (Inspirational)	
due to	

Other conditions: Multiple hemorrhages - adrenal pericardium: dilatation bladder. Retention urine
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John P. Clam D.O. M. D. or other
Address: Hyattsville Date signed 7-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

67173

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH ★

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Geo.
City or town Croom
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Garner Wm. Ernest

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1876

8. AGE: Years	Months	Days	If less than one day
69	3	3	hrs. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Wm. F. Garner
13. Birthplace Md.

MOTHER
14. Maiden name Susan Rawlings
15. Birthplace Md.

16. Informant Everett Garner (Son)
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7-12-45 (month) (day) (year)
Cemetery or crematory Brookfield
Location Naylor, Md.
18. Funeral director Tilghman Bros.
Address Upper Marlboro, Md.
19. 7/9 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9 19 45 at 6 05 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-8 19 45 to 7-9 19 45
and that I last saw h[illegible] alive on 7-9 19 45

Immediate cause of death	DURATION
Cardiac Failure	
Due to Hypertension, arteriosclerotic Cardio Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Thompson M. D. or other
Address Prince George Gen Hosp Cheverly, Md Date signed 7-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07174

(13?)

★ Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 25 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 732 Balls Court N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

WARDDELL GASKINS

3.(b) Social Security Number

–

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1933

8. AGE: Years	Months	Days	If less than one day
12	2	22	hrs. min.

9. Birthplace: McCormick, South Carolina
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER
12. Name: William T. Gaskins
13. Birthplace: McCormick, South Carolina

MOTHER
14. Maiden name: Carrie Talbert
15. Birthplace: McCormick, South Carolina

16. Informant: Decedent.
Address:

17. Burial, cremation, or removal. Which? Removal Date thereof July 10 1945
(month) (day) (year)

Cemetery or crematory: Removal D. C.

Location: Wash., D. C.

18. Funeral director: BOHRE

Address: 22 Seward

19. July 10 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 10 1945, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 15 1945, to JULY 10 1945

and that I last saw h. i.m. alive on JULY 10 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 7/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

CERTIFICATE OF DEATH

(6717)

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges
City or town: College Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6900 - Dartmouth ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Jane Goodrich

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles F
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 16, 1870

8. AGE: Years: 75 | Months: 0 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Hardin Ohio.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: William Marshall
13. Birthplace: Ohio

MOTHER
14. Maiden name: Sarah Davis
15. Birthplace: Ohio

16. Informant: Mrs Mary J Green
Address: 6900 - Dartmouth ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25, 1945 (month) (day) (year)
Cemetery or crematory: Geo Wash. Memo Park Cem
Location: Hyattsville Md.

18. Funeral director: H. H. Chambers Co
Address: Riverdale, Md.

19. July 24, 1945 (Date rec'd by registrar) James Devey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23, 1945, at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1945, to July 23, 1945 and that I last saw her alive on July 22, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days.
Due to: Arteriosclerosis	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Louis Mendel major MC USA
M. D. or other
Address: 6806 Dartmouth Ave Date signed: 7/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

07176

CERTIFICATE OF DEATH ★

Reg. Dist. No. 240

1. PLACE OF DEATH:

County Prince George

City or town Cedersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Cedersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Virgie Estelle Graham

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 8, 1927

8. AGE:

Years	Months	Days	If less than one day
18	3	6	..... hrs. ..... min.

9. Birthplace Washington, D.C.

(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name William Graham

13. Birthplace Maryland

MOTHER 14. Maiden name Arlee Cooper

15. Birthplace Maryland

16. Informant William Graham

Address Cedersville md

17. Burial Date thereof July 17-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peters

Location Waldorf md

18. Funeral director Hurst & Byrn

Address Waldorf md

19. July 17 19 45 F. H. Billingsley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Toxemia of Pregnancy	
Due to Tuberculosis Pulmonary Acute Miliary Tuberculosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Forestville md Date signed 7-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

(7177

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Landover Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Landover Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6208 Oston Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Coleman Graves

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

B.(b) Name of husband or wife: Kendall E Graves
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 10, 1867

8. AGE:

Years	Months	Days	If less than one day
77			..... hrs. ..... min.

9. Birthplace: Rhode Island (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Smith
13. Birthplace: Scotland

MOTHER
14. Maiden name: Harriet Coleman
15. Birthplace: Rhode Island

16. Informant: Emma Wright
Address: 4204 - 30th St Mt Ranier Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md

18. Funeral director: F Gaschi's sons
Address: Hyattsville Md.

19. 7/2 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 - 1 1945, at 2A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 17 1945, to July 1 1945
and that I last saw h.e.r. alive on July 1 1945
Immediate cause of death: Cerebral Apoplexy

DURATION

Due to: Arteria sclerotic Heart
& Kidney disease
Due to: Senility
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George Hagiagu M.D. M. D. or other
Address: 3217 38th Pl Date signed 7-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-E)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 07172 239

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: Dead on arrival at Dr Warners Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 Washington Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Elwood Griffith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia Griffith
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Aug 30, 1888

8. AGE: Years: 56 | Months: 10 | Days: 14 | If less than one day: ... hrs. ... min.

9. Birthplace: Upper Marlboro, Md (Town, county, and state)
10. Usual occupation: Chief Personnel
11. Industry or business: Fort Meade

FATHER
12. Name: Thomas Griffith
13. Birthplace: Georgetown Md

MOTHER
14. Maiden name: Anna Miles
15. Birthplace: Washington D.C.

16. Informant: Mrs Virginia Griffith
Address: Laurel, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 17-45 (month) (day) (year)
Cemetery or crematory: Arlington Nat'l Cemetery
Location: Va
18. Funeral director: [illegible]
Address: Laurel Md

19. July 15 (Date rec'd by registrar) 1945 M. Brashears Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1945 at 7.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to: Crushed skull	
Crushed chest	
Due to: Fractured pelvis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 7-14-45
Where did injury occur? Laurel (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?): Route # 1
Means of injury: Driving Car run Called Injured at work? no
Deputy medical examiner

23. SIGNATURE: [illegible] M. D. or other
Address: Forestville Md Date signed: 7-14-45

Change of second initial of deceased: letter from J. Wm. Lee's sons filmed 8-6-45 G97 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-d)

CERTIFICATE OF DEATH

(717) Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Prince Georgis General Hosp.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1316 Staples Pl. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Hackett, Lester W.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	

6.(b) Name of husband or wife: Mildred V. Hackett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 11 - 1907

8. AGE: Years	Months	Days	If less than one day
38	6	14	4 hrs. 45 min.

9. Birthplace: Iowa (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business

FATHER
12. Name: Arthur J. Hackett
13. Birthplace: Indiana

MOTHER
14. Maiden name: Lenore Small
15. Birthplace: Wisconsin

16. Informant: Mildred V. Hackett
Address: 1316 Staples Pl. N.E. D.C.

17. Burial, Removal (Burial, cremation, or removal. Which?) Date thereof: July 25-45 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Cottage City, Md.

19. Funeral director: J. William Lee's Sons Co.
Address: 709-11 St. N.E. Wash. D.C.

19. 7/25/45 (Date rec'd by registrar) Amanda Downey, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1945, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 24, 1945 to July 24, 1945 and that I last saw him alive on July 24, 1945

Immediate cause of death	DURATION
Cardio respiratory failure	
Due to: Myocardial degeneration & probable Coronary Thrombosis	
Due to:	
Other conditions: Chronic Alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. M. Jones, M. D. or other
Address: Prince Geo Hosp. Cheverly, Md. Date signed: 7-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07180

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 5 mos., 27 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 yrs., 5 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1320 Harvard St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH EDWARD HARGRAVE

3.(b) Social Security Number: 228-03-3292

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 11, 1917

8. AGE: Years	Months	Days	If less than one day
27	8	21	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Grocery Clerk
11. Industry or business: –

FATHER
12. Name: Joseph Edward Hargrave
13. Birthplace: Virginia

MOTHER
14. Maiden name: Rosa Crouch
15. Birthplace: Virginia

16. Informant: Decedent
Address

17. Removal to
(Burial, cremation, or removal. Which?)
Date thereof: July 3, 1945
(month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: W.W. Chambers Rer Hurst
Address: 517 11th St SE
19. July 2 19 45 Rowland S Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1945, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1942, to July 2 1945, and that I last saw h(M)M alive on July 2 1945.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	4 yrs 6 Mo
Due to: Tuberculous Enteritis	16 Mo
Fatal Hemorrhage	–
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincura M.D.
M. D. or other
Address: Glenn Dale Md. Date signed: 7/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

C7181

Reg. Dist. No. 2-3-4

1. PLACE OF DEATH:

County Prince Georges

City or town Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

6300 - Railroad Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6300 Railroad Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Wolfgange Herath

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Magdalene Herath

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) June 10, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	14	...hrs. ...min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Retired Baker

11. Industry or business Baking

FATHER 12. Name John Herath

13. Birthplace Germany

MOTHER 14. Maiden name Ena Wolfgange

15. Birthplace Germany

16. Informant Mrs Magdalene Herath

Address Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26-1945 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland Maryland

18. Funeral director Thomas F. Murray

Address 2007 - Nichols Ave SE

19. July 25 1945 (Date rec'd by registrar) Howard I Bond Registrar.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Cardio vascular renal disease	
Due to	
Other conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operation... Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

Deputy medical Examiner

23. SIGNATURE James H Boyd M. D. or other

Address Prestwick Md Date signed 7-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

07182

★ Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges.
City or town: College Park.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: 6807 Dartmouth ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges.
City or town: College Park.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6807 - Dartmouth ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Etta Hewes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles T. Hewes.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1859

8. AGE: Years: 86 | Months: 5 | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Payson Ill.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER
12. Name: George Sinnock
13. Birthplace: England.

MOTHER
14. Maiden name: Sarah Ann Kay
15. Birthplace: Kentucky

16. Informant: Lois E. Hewes. College
Address: 6807 - Dartmouth ave. Pk.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27, 1945 (month) (day) (year)
Cemetery or crematory: Woodland Cemetery
Location: Quincy Ill

18. Funeral director: H. H. Chambers Co.
Address: Riverdale Md.

19. July 26, 1945 (Date received by registrar) James Sevey, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26th 1945 at 7.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardio-vascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Deputy medical Examiner

23. SIGNATURE: James D. Ford, M. D. or other
Address: Forestville Md. Date signed 7-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

07183

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Prince George's
City or town Roger Heights Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Roger Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5014 54th avenue,.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME Charles Edwards Hine

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife Carline A Hine
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 30 1863

8. AGE: Years	Months	Days	If less than one day
81 years			....hrs. ....min.

9. Birthplace New York
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Woodworking Machinist

FATHER 12. Name William Hine
13. Birthplace New York

MOTHER 14. Maiden name Lida Ann Edwards
15. Birthplace New York

16. Informant Harry H. Kercheval
Address Roger Heights Maryland.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof July 5. 1945 (month) (day) (year)
Cemetery or crematory Friends Cemetery
Location Cornwall New York

18. Funeral director L Gasch's Sons
Address Hyattsville Md

19. July 7 1945 (Date rec'd by registrar) James Secor (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1945. 19.... at 11:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-14-44 19.... to 7-3 19.45 and that I last saw h.. l.. alive on 7-2-45 19....

Immediate cause of death	DURATION
Cerebral Thrombosis	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John P. Clum M.D.
M. D. or other
Address Hyattsville Date signed 7-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

07184

CERTIFICATE OF DEATH ★

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges
City or town: Riverdale Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 days
Hospital, institution, or street address where death occurred: Leland Memorial Hospital
How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4809 Rhode Island Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth Anna Holroyd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	W	widowed

6.(b) Name of husband or wife: Fred Holroyd deceased
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): February 1874

8. AGE: Years: 71 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: England (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: Edward Riley
13. Birthplace: unknown

MOTHER
14. Maiden name: Anna ?
15. Birthplace: unknown

16. Informant: Hospital Records
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10. 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Md
18. Funeral director: F. Gaddis & Sons
Address: Hyattsville Md
19. July 10 1945 James Devery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1945, at 6.50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1945 to July 6 1945
and that I last saw h[illegible]er alive on July 6 1945
Immediate cause of death: Acute Coronary Occlusion — DURATION: June 8
Due to: arteriosclerotic heart disease — 7 yrs
Due to: Hypertension — 20 yrs
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: None — Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. E. Malin M.D.
M. D. or other
Address: Riverdale Md Date signed 7/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07185

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Kenilworth
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Kenilworth
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1421 Eastern ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: MARY MARGARET HORAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Charles H. Horan
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): June 6th 1874

8. AGE: Years: 71 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: William Clark
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Fowler
15. Birthplace: Ireland

16. Informant: Mrs. Charles H. Horan
Address: 1421 Eastern ave. Kenilworth Md.

17. Burial (Burial, cremation, or removal. Which?): Burial Date thereof: 7-19-45 (month) (day) (year)
Cemetery or crematory: Congressional
Location: Washington D.C.

18. Funeral director: W. W. Chambers Co.
Address: 519 11th St S.E.

19. 7-18 19 45 (Date rec'd by registrar) Carrie J. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 19 45 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 44 to July 18 19 45 and that I last saw her alive on July 18 19 45

Immediate cause of death	DURATION
Cardio vascular Renal Disease	5 Years
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. I. E. Hurst M.D. M. D. or other
Address: 4101 Minn ave NE Washington D.C. Date signed: 7-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-4)

CERTIFICATE OF DEATH

07186

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 768 Irving St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JACKSON, ROBERT

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Annie Jackson

6.(c) If alive, give age: dec. years

7. Birth date of deceased (mo., day, yr.): June 1, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	1	20	...hrs. ...min.

9. Birthplace: Orange, Virginia
(Town, county, and state)

10. Usual occupation: Govt. Messenger

11. Industry or business:

FATHER
12. Name: Robert Jackson
13. Birthplace: Orange, Virginia

MOTHER
14. Maiden name: ?
15. Birthplace: Virginia

16. Informant: Decedent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-23-45 (month) (day) (year)
Cemetery or crematory: to Washington
Location:

18. Funeral director: L. E. Simms & Sons
Address: 337-10 St N.W. Wash. D.C.

19. July 21, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21, 1945, at 8:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1945 to July 21 1945 and that I last saw him alive on July 21 1945

Immediate cause of death	DURATION
Tuberculosis, pulmonary	5 mos.
Due to:	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 7/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-e)

CERTIFICATE OF DEATH

(7187

★ Reg. Dist. No. 230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: PRINCE GEORGES

City or town: BELTSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 YRS.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MD. County: PR. GEO

City or town: BELTSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: ANNA ELIZ. KING

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	MARRIED

6.(b) Name of husband or wife: FREDERICK D. KING

6.(c) If alive, give age: ....years

7. Birth date of deceased (mo., day, yr.): SEPT 10, 1864

8. AGE: Years	Months	Days	If less than one day
80	10	15	....hrs. ....min.

9. Birthplace: SILVER SPRING, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: BENJ. SCHRIDER

13. Birthplace: GERMANY

MOTHER 14. Maiden name: SUSAN KING

15. Birthplace: MONT. CO. MD.

16. Informant: FREDERICK D. KING

Address: BELTSVILLE MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27, 1945 (month) (day) (year)

Cemetery or crematory: Mt Lincoln Cemetery

Location: Blademsburg Rd at D C Line

18. Funeral director: J. ARTHUR WALTERS

Address: 234 CARROLL ST. N.W. TAKOMA PARK, D.C.

19. July 27 1945 (Date rec'd by registrar) JOHN D. SMITH Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1945, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1944, to July 24 1945

and that I last saw h.e.r. alive on July 23 1945

Immediate cause of death	DURATION
Carcinoma of Mouth	3 yrs +
Due to	
Due to	
Other conditions Contracture of Left Hip	1945

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. O'Etienne MD
M. D. or other

Address: 4713 Rhode Island Ave Date signed: July 26 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

07188

★ Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Georges.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Georges.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3902. Oliver st. Hyattsville
(If rural, give LOCATION)
2.(a) If veteran, name war: no.

3.(a) FULL NAME Edward Lartigue

3.(b) Social Security Number 702-16-1163

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Ellen

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 25th 1876.

8. AGE: Years	Months	Days	If less than one day
69	4	10	hrs. min.

9. Birthplace: Mobile, Ala
(Town, county, and state)

10. Usual occupation: Retired (R.R.)

11. Industry or business

FATHER
12. Name: Theo. Lartigue
13. Birthplace: Ala.

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: John J. Reinhardt.
Address: 3915. Oliver st. Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 7th 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery.
Location: Bladensburgh, Md.

18. Funeral director: A. A. Chambers Co.
Address: 5801- Cleveland ave. Riverdale Md.

19. July 7 1945 James Berry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1945 at 8:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945, to July 5 1945 and that I last saw him alive on July 4, 1945

Immediate cause of death	DURATION
Carcinoma, tonsil	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R. Shea M.D.
M. D. or other
Address: 4100-42nd St. N.E. Washington D.C. Date signed: 7/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07189

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH ★

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 hours
Hospital, institution, or street address where death occurred: Prince George Gen Hosp
How long in hospital or institution? 11 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Branchville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4902 Blackfoot Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Baby boy LePire

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years | Months | Days | If less than one day: 11 hrs. min.

9. Birthplace: Prince George Gen Hospital Cheverly Md
(Town, county, and state)

10. Usual occupation: Newborn

11. Industry or business:

MOTHER FATHER
12. Name: Joseph LePire
13. Birthplace: North Dakota
MOTHER
14. Maiden name: Edith Graff
15. Birthplace: D.C.

16. Informant: father Joseph LePire
Address: 4902 Black Foot Rd. Branchville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington, D.C.

18. Funeral director: F. Rosario Dove
Address: Bladensburg Md

19. 7/12 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-11 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-11 1945, to 7-11 1945
and that I last saw him alive on 7-11 1945
Immediate cause of death: Premature birth

	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J M Jernigan M. D. or other
Address: Prince Geo Gen Hosp Cheverly Md Date signed: 7-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07190 ★ Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George Co.
City or town: Kenhallworth
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. George
City or town: Kennelworth
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4607 Addison Chapel Road
(If rural, give LOCATION)
2.(a) If veteran, name war: Sp. American & World War I

3. (a) FULL NAME: AMOS C. LIETZ.

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances Lietz
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): January 8, 1875

8. AGE: Years	Months	Days	If less than one day
70	6	22	..... hrs. ..... min.

9. Birthplace: Stolp, Germany (Town, county, and state)
10. Usual occupation: Attorney - Retired
11. Industry or business: Veternas Administration

FATHER
12. Name: Henry Lietz
13. Birthplace: Germany

MOTHER
14. Maiden name: Emma Laura Stritzel
15. Birthplace: Germany

16. Informant: Leo D. Lietz
Address: 4607 Addison Chapel Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 1, 1945 (month) (day) (year)
Cemetery or crematory: Mount Olivet Cemetery
Location: Washington, D.C.
18. Funeral director: James F. Ryan Inc.
Address: 317 Penna. Ave., S.E. D.C. #3

19. 7-30 (Date rec'd by registrar) 19 45 Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1945, at 1.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1945, to July 30, 1945 and that I last saw h... alive on July 29 1945

Immediate cause of death	DURATION
Coronary Thrombosis.	3 Days.
Due to	
Due to	
Other conditions	

(Includo pregnancy within 8 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. A. Connor M.D. M. D. or other
Address: 2026-16th St. N.W. Washington D.C. Date signed: 7/30/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

(7191)

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George.
City or town Cottage City Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Cottage City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3709 - 40th Pl.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CLAUDIUS A. LIGHTNER.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	married

6.(b) Name of husband or wife Carrie Virginia
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 16 - 1875

8. AGE: Years 69 | Months | Days | If less than one day hrs. min.

9. Birthplace Warren Pa. (Town, county, and state)
10. Usual occupation Floor Walker.
11. Industry or business Kanns Dept. Store
FATHER 12. Name Wm Lightner
13. Birthplace Pa.
MOTHER 14. Maiden name Mary L. Wetmore
15. Birthplace Pa
16. Informant Mrs Carrie V. Lightner
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location
18. Funeral director W. W. Chambers Co.
Address 517 - 11 St. S.E.
19. 7/8 1945 Amanda Denny
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8 1945, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/10 1938 to 7/8 1945
and that I last saw h/im alive on 7/8 1945
Immediate cause of death Carcinoma of rectum — DURATION
Due to Metastasis gen.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. J. Hagerage M. D. or other
Address 3717 38th Ave. Date signed 7/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

07192

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince George
City or town Chevrerly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 days
Hospital, institution, or street address where death occurred:
Prince George's General Hosp.
How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317 Montgomery St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Likens, Mr. William Edward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Agnes Hurley Likens
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1876

8. AGE: Years	Months	Days	If less than one day
68	10	26	..... hrs. ..... min.

9. Birthplace N. J.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Mrs. Marion Watson
Address 317 Montgomery St. Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1945 (month) (day) (year)
Cemetery or crematory St. Mary's
Location Laurel Md.

18. Funeral director Leo H. Hewitt & Donaldson
Address Laurel Md.

19. 7/28 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1945 to July 28 1945 and that I last saw him alive on July 27 1945

Immediate cause of death Peripheral Vascular Collapse

	DURATION
Due to Congestive heart failure	
Due to Hypertensive Cardio vascular renal Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results Same.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. M. Brogan M. D. or other
Address Prince Geo. Clinic Date signed 7-28-45

RECEIVED
JUL 31 1945
BUREAU V.S.

1945 - 7 - 28
1876 9 - 3
68 10 - 25

1945
69
76

Evidence for addition of date of death is shown on

FILM No. G 97 JUL 27 1945

STATE OF MARYLAND—CERTIFICATE OF DEATH

07193

(159)

1. PLACE OF DEATH

County Prince Georges. Registration Dist. No. 231

Village or City Beverly No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred Life mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Donald H. MacLellan Jr If U. S. Veteran, specify WAR —

(a) Residence: No. 4-G Plateau place. St., Ward —

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X X X

6. DATE OF BIRTH (month, day, and year) July 18, 1945

7. AGE Years	Months	Days	If LESS than ~~1 day~~, 14 hrs. or ~~1~~ 14 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Prince Georges. City Md.

FATHER

13. NAME Donald H. MacLellan

14. BIRTHPLACE (city or town) (State or country) Portland Me

MOTHER

15. MAIDEN NAME Estella Casgro

16. BIRTHPLACE (city or town) (State or country) Dorchester Mass.

17. INFORMANT (Address) Mrs Estella MacLellan 4-G Plateau place Greenbelt Md.

18. BURIAL, ~~CREMATION~~, OR REMOVAL Place Arlington Natl Cem. Va. Date July 20, 1945

19. UNDERTAKER (Address) H. H. Chambers Co. Riverdale Md.

20. FILED 7/19, 1945 Amanda Downey Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 19 (Day) ~~193~~ 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 7/18, 1945, to 7-19, 1945

I last saw h[illegible] alive on 7-19-, 1945; death is said to have occurred on the date stated above, at 10 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Respiratory failure	
Laryngeal Obstruction	
Other Contributory Causes of Importance:	
Prematurity	

Name of operation — Data of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) William M. Ecsmen M. D.

(Address) Greenbelt Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

07194

CERTIFICATE OF DEATH

Reg. Diat. No. 239

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County Prince George's
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 years
Hospital, Institution, or street address where death occurred:
205 Wilson St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 205 Wilson St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ralph Lee Merson

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

B.(b) Name of husband or wife Florentine Merson
B.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) January 25, 1904

8. AGE: Years	Months	Days	If less than one day
41	5	20	..... hrs. ..... min.

9. Birthplace Laurel, Pr. Geo's Co., Maryland (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business

FATHER
12. Name Thomas Wesley Merson
13. Birthplace Burtonsville, Maryland

MOTHER
14. Maiden name Amanda Merdon
15. Birthplace Laurel, Maryland

16. Informant Mrs. Betty D. Calhoun
Address 205 Wilson St., Laurel, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17-1945 (month) (day) (year)
Cemetery or crematory Ivy Hill
Location Laurel Md
18. Funeral director The H. C. White Co. Inc.
Address Laurel Md

19. July 17 1945 (Date rec'd by registrar) Cora E. Wachter Deputy. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28 1945 to July 15 1945 and that I last saw him alive on July 13 1945

	DURATION
Immediate cause of death Acute Cardiac Decompensation, Generalized Metastasis from	
Due to Carcinoma of Lung.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Rt. C. Left Lung. Removed Date of op. April 28 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R B Robertson M. D. or other
Address 305 Pr. Geo. St. Laurel Md Date signed 7-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

07195

CERTIFICATE OF DEATH

★ Reg. Diat. No. 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred: Warren Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Guilford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lucy Mitchell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife: George R Mitchell
B.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1874

8. AGE:

Years	Months	Days	If less than one day
70	8	17	...hrs. ...min.

9. Birthplace: Treadways, Tennessee
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: ? Drury
13. Birthplace: Tennessee

MOTHER
14. Maiden name: ? Cantwell
15. Birthplace: Tennessee

16. Informant: Miss Mary Mitchell
Address: Jessup P. O. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23 1945 (month) (day) (year)
Cemetery or crematory: Christ Church Cem.
Location: Guilford, Md.

18. Funeral director: Easton Sons
Address: Ellicott City, Md.

19. July 22 19 45 (Date rec'd by registrar) Cora E. Wachter Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 21 1945 at 2 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 7 1945 to 3 21 1945 and that I last saw h... alive on 7 21 1945

Immediate cause of death	DURATION
Apoplexy	2 Hrs
Arteriosclerosis	
Due to: Myocardial failure	
Due to: Chr. Nephritis	7-8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. Warren M. D. or other
Address: Laurel Md Date signed: 7 21 45

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07196

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bfa)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County Prince Georges
City or town Tuxedo (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Prince Georges
City or town Tuxedo (If outside city or town limits, write RURAL and give nearest town)
Street No. 5810 arbor St (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lillian T Mulloy
3. (b) Social Security Number

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Samuel J.
6. (c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) April 19 1876
8. AGE: Years 69 Months Days If less than one day ... hrs. ... min.
9. Birthplace Washington DC (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name William Taylor
13. Birthplace Md
MOTHER 14. Maiden name Mary Windsor
15. Birthplace Washington DC
16. Informant Lillian T Weaver
Address 5810 arbor St Tuxedo Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9 1945 (month) (day) (year)
Cemetery or crematory Fort Lincoln Cem
Location
18. Funeral director J. Wm Lees Sons
Address 300-4th St NE
19. 7/6 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/6 1945, at 9:15 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6/20 1940, to 7/6 1945
and that I last saw her alive on 7/6 1945
Immediate cause of death Myocardial decompensation
Due to Hypertensive Heart + kidney disease
Due to Nephrolithiasis
Other conditions
(Include pregnancy within 3 months of death)
DURATION
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George J Hagenga MD, M. D. or other
Address 3717 38th Ave Date signed 7/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

67197

Reg. Diat. No. 232

1. PLACE OF DEATH:

County: Prince Georges

City or town: Brandywine, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred: was in Casualty Hospital Gwalds

How long in hospital or institution? Freedmen Hospital Gwalds

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Faulkner

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Sarah Ann Newman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: John B. Newman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 1st 1877

8. AGE:

Years	Months	Days	If less than one day
67	11	1	..... hrs. ..... min.

9. Birthplace: Faulkner, Md.

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER

12. Name: John Queen

13. Birthplace: Faulkner Md

MOTHER

14. Maiden name: Birdie Thompson

15. Birthplace: Faulkner Md

16. Informant: John Spencer Newman

Address: Brandywine Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof July 6, 1945 (month) (day) (year)

Cemetery or crematory: St Lynchen Cemetery

Location: Glenarden Forest Md

18. Funeral director: Smith & Ryon

Address: Waldorf Md

19. July 3rd 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1st 1945 at 0130 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 27 1945 to July 1st 1945

and that I last saw her alive on July 1st 1945

	DURATION
Immediate cause of death: Coma	4 days
Due to: Chronic Brights Disease	7 Year
Due to: High Blood Pressure	several Years
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John E. Bowers, M.D. M. D. or other

Address: Brandywine Md Date signed 7/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

07198

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Prince Georges
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, Institution or~~ street address where death occurred:
411 Circle Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 411 Circle Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: DAVID ALTON OSBOURN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Irene Schoppert
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 23rd. 1857

8. AGE: Years	Months	Days	If less than one day
87	11	15	..... hrs. ..... min.

9. Birthplace: Sandy Ridge, W. Va.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: John Osbourn
13. Birthplace: Sandy Ridge, W. Va.

MOTHER
14. Maiden name: Jane Link
15. Birthplace: W. Va.

16. Informant: Mrs. Nell McGath, daughter
Address: 411 Circle Ave. Tak. Pk. Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 7/12/45
(month) (day) (year)

Cemetery or crematory: Edge Hill
Location: Charles Town, Jefferson Co. W.Va.

18. Funeral director: Adams & Pumphrey
Address: 8434 Ga. Ave. Silver Spring, Md.

19. July 10 1945 Josephine M Schaeffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1945, at 9.45- M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1945, to July 8 1945
and that I last saw him alive on July 8, 1945

Immediate cause of death	DURATION
Uremia	2 days
Chronic interstitial nephritis	
Due to: Duration: 3 years. C.C.&S.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of: ✓
Where did injury occur? ✓ (City or town) ✓ (County) ✓ (State)
Injured at home, farm, industry, public place (where?): ✓
Means of injury: ✓ Injured at work? ✓

23. SIGNATURE: L. B. Byrington, M.D.
M. D. or other
Address: 1832 Biltmore St. N.W. Date signed: 7-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

07199

CERTIFICATE OF DEATH

★ Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo.; 13 hrs.; 25 min.

Hospital, Institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or institution? 2 mo.; 13 hrs.; 25 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State (x) Maryland County Prince Georges

City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)

Street No. 34 & Ridge Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Esther Catherine Pennella

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~ Angelo Pennella

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) June 12, 1912.

8. AGE: Years	Months	Days	If less than one day
33	1	2	..... hrs. ..... min.

9. Birthplace Brooklyn, New York.
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home.

FATHER
12. Name Anthony Largiani.
13. Birthplace Italy

MOTHER
14. Maiden name Mary Bertolino
15. Birthplace Italy.

16. Informant patient's chart.
Address

17. Burial, cremation, or removal. Which? transportation
Date thereof July 15, 1945 (month) (day) (year)

Cemetery or crematory Scranton
Location Pennsylvania

18. Funeral director E. Steele Sons
Address Hyattsville Md.

19. July 14 1945 (Date rec'd by registrar) James Seivy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-10 1945, to 7-14 1945 and that I last saw h.e.r alive on 7-13-45 1945

Immediate cause of death	DURATION
Adenocarcinoma of colon	1 yr.
Due to	
Due to	
Other conditions Fecal vomit, Peritonitis (Include pregnancy within 3 months of death)	3 wks.

Major findings of operations obstruction of bowel

Date of op. 5/10/45 5/20/45

Autopsy results Peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, Industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE W. E. Malin M.D.
M.D. or other

Address Riverdale, Md. Date signed 7/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8300

07200

CERTIFICATE OF DEATH

★ Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Edmonston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
4920 Taylor Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Edmonston
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4920 Taylor Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ELIZABETH PHILLIPS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles N. Phillips
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 30, 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	10	25		

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: Bernard L. Kaiser
13. Birthplace: Germany

MOTHER
14. Maiden name: Katherine Geier
15. Birthplace: Germany

16. Informant: Ada M. Brown
Address: 1427 Eastern Av. Kenilworth, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor, Md.

18. Funeral director: F. Gasch's Sons
Address: Hyattsville, Md.

19. July 27, 1945 (Date received by registrar) James Every Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1945 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to 7-25 1945 and that I last saw her alive on 7-25- 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	36 hrs
Due to: Arterio sclerosis	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jeremy Hays M. D. or other
Address: Hyatts. Md. Date signed 7-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

07201

CERTIFICATE OF DEATH ★

Reg. Diat. No. 242

1. PLACE OF DEATH:

County Prince George

City or town Fort Foote

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

6871 - Oxon Hill Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Fort Foote

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6871 Oxon Hill Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lilly May Piskerall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Jesse E. Piskerall

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 28, 1881

8. AGE: Years	Months	Days	If less than one day
64	3	10	...hrs. ...min.

9. Birthplace Charles County, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER — 12. Name George Washington Willett

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden name Matilda Piskerall

MOTHER — 15. Birthplace Maryland

16. Informant Mary J. Stubblefield

Address 6871 Oxon Hill Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-10-45 (month) (day) (year)

Cemetery or crematory Christ Church

Location Accokeek Md.

18. Funeral director W. W. Chambers Co.

Address 517 11th St. S.E.

19. July 9 1945 (Date rec'd by registrar) Carrie F. Campbell (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death Congestive heart failure	
Due to Toxic Myocarditis	
Due to Bronchopneumonia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE James E. Boyd M. D. or other

Address Forestville Md. Date signed 7-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

07202 2442

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fourth Park, Lanham

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Fourth Park, Lanham Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary Ellen Pierce

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry W.

6(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): April 29th 1899

8. AGE: Years: 56 Months: Days: If less than one day: hrs. min.

9. Birthplace (Town, county and state):

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Benjamin Floyd

13. Birthplace: Md.

MOTHER 14. Maiden name: Frances C. Gardner

15. Birthplace: Md.

16. Informant: Mrs. J. Pierce

Address: Lindsley Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7. 19. 45 (month) (day) (year)

Cemetery or crematory: Ebenezer Lanham Md.

Location: Lanham Md.

18. Funeral director: Chas Frazier & Son

Address: 3809 R.I. Ave. NW. D.C.

19. July 16 19 45 (Date rec'd by registrar) Mrs Jack Bennette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945, at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1944, to July 15 1945, and that I last saw her alive on July 15 1945.

	DURATION
Immediate cause of death: Cerebral Haemorrhage	1 mo.
Due to: Hypertension	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert J. McEnery M. D. or other

Address: 402 Main St Laurel Md. Date signed: 7/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

07203

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince Georges
City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: 5300 Oxon Hill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5300 Oxon Hill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Edith Joan Proctor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 20, 1905

8. AGE: Years 39 Months Days 6 If less than one day ..... hrs. ..... min.

9. Birthplace Oxon Hill, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Joseph William Proctor
13. Birthplace Maryland

MOTHER 14. Maiden name Clara Estelle Brooks
15. Birthplace Maryland

16. Informant Ernest Brooks
Address Oxon Hill Md Rt 1

17. Removal. (Burial, cremation, or removal. Which?) Date thereof 7-27-45 (month) (day) (year)

Cemetery or crematory
Location Washington D.C.

18. Funeral director John T. Rhines Co
Address 601 3rd ST. SW

19 July 26 1945 (Date rec'd by registrar) Thos. J. Leffler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 4 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Toxemia	
Due to: Bronchopneumonia	
Due to:	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other
Address Forestville Md Date signed 7-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

07204

CERTIFICATE OF DEATH

★ Reg. Diat. No. 231

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Prince Geo.
City or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infnots give residence of mother)
State Md. County Prince Geo.
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rnrnl, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Rawlings, Mr. James

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1869

8. AGE: Years 75 | Months 9 | Days 6 | If less than one day ... hrs. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Rawlings, Mr. Jas. Henry
FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Wilson, Martha Eliz.
MOTHER 15. Birthplace Md.

16. Informant Son - Rawlings, Mr. Hugh
Address Brandywine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-30-45 (month) (day) (year)
Cemetery or crematory
Location Brandywine, Md.

18. Funeral director Ritchie Bros.
Address Upper Marlboro, Md.

19. 7/30/45 (Date rec'd by registrar) Amanda L. Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1945, to July 30 1945 and that I last saw h. liv. alive on July 30 1945

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular-Renal Disease	5 yrs
Due to Arteriosclerosis	10 yrs
Due to	
Other conditions Senility	1 year

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. —

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James L. Harrow M. D. or other
Address Upper Marlboro, Md. Date signed 7-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

07205

Reg. Dist. No. 240

1. PLACE OF DEATH:
County Prince Georges
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ella Frances Richards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John Allen Richards
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1881

8. AGE:

Years	Months	Days	If less than one day
63	9	20	..... hrs. ..... min.

9. Birthplace Prince George Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
12. FATHER Name Charles Lincoln Bateler
13. Birthplace Maryland
14. MOTHER Maiden name Margaret Garner
15. Birthplace Maryland
16. Informant John Allen Richards
Address Brandywine Md.
17. Burial Date thereof July 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Emmanuel Church
Location Hodge Heaft, Co. Geo's Co.
18. Funeral director Ritchie Bros
Address Upper Marlboro Md.
19. July 19 1945 F. W. Billingsley
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 5-45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
Deputy medical Examiner
23. SIGNATURE James W. Bond M. D. or other
Address Forestville Md. Date signed 7-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. G 97 JUL 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

07206

★ Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Geo.
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Prince Geo. Hospt.
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Geo.
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6217 Forest Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Rollins, Miss Louise

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21 - 75

8. AGE: Years	Months	Days	If less than one day
69 ~~70~~			hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: U.S. gov.

FATHER
12. Name: John Rollins
13. Birthplace: Va.

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: R. M. Carnana
Address: 6217 Forest Rd, Cheverly, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Glenwood Cem. 7-21-45
Location: Wash. D.C.

18. Funeral director: William Lee Lewis Co.
Address: 300 - 4 St N.E. D.C.

19. 7/19 1945 (Date rec'd by registrar) Amanda Dimney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-17 1945 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-12 1945, to 7-17 1945
and that I last saw h[illegible] alive on 7-11-45 1945

Immediate cause of death	DURATION
Cancer Ovary	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other
Address: Colmar Bldg. Date signed: 7-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07207

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 802 A. St. N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Minnie Rouzer

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 22, 1869

8. AGE: Years	Months	Days	If less than one day
75	7	25	hrs. min.

9. Birthplace: Carolina, Virginia
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Thomas Chinault
13. Birthplace: Carolina, Virginia

MOTHER
14. Maiden name: Mary Searles
15. Birthplace: Carolina, Virginia

16. Informant: Decedent
Address:

17. Burial, cremation, or removal. Which? Removal Date thereof: July 17, 1945 (month) (day) (year)

Cemetery or crematory: Washington,

Location: D. C. Penn

18. Funeral director: W. W. Chambers Hurst.

Address: 512 11th St. S.E.

19. (Date rec'd by registrar) July 17 1945 Rowland S. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1945, at 11:30a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1945, to July 17 1945 and that I last saw h. alive on July 17 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	4 mo.
Tuberculous enteritis	2 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Lee Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 7/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. G 97 JUL 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 245 — 17208

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George's
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo Co
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5108 42 avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William Alexander Shepherd

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Maie G. Shepherd
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): August 10, 1868

8. AGE: Years	Months	Days	If less than one day
76 ~~77~~	11	23	...hrs. ...min.

9. Birthplace: Washington D. C.
(Town, county, and state)
10. Usual occupation: City Treasurer
11. Industry or business

FATHER
12. Name: William S. Shepherd
13. Birthplace: Washington D. C.

MOTHER
14. Maiden name: Laura A Shepherd
15. Birthplace: Washington D. C.

16. Informant: Mrs Maie Shepherd
Address: Hyattsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Colmar Manor Maryland

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland

19. July 24 1945 (date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 1945, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to July 23 1945
and that I last saw h...alive on July 23 1945

Immediate cause of death	DURATION
Carcinoma, Pylaric	
Due to	1 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos. E. Johnson M.D. or other
Address: 4108 Jefferson Hyattsville Date signed: July 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

07209

Reg. Dist. No. 542

1. PLACE OF DEATH:
County: Prince George
City or town: Clinton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo.
City or town: Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Simpson Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Alice Mary Simpson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	us White	married

6.(b) Name of husband or wife: William Simpson
6.(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): Sept 27 1892

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: at home
FATHER — 12. Name: Adolf Von Haake
FATHER — 13. Birthplace: Germany.
MOTHER — 14. Maiden name: Alice (unknown)
MOTHER — 15. Birthplace: Washington D.C.
16. Informant: William Simpson
Address: Clinton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/30/45 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.
16. Funeral director: H. H. Chambers Co
Address: 517 - 11 - St. S.E. (D.C.)
19. July 29 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1945 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to July 27 1945 and that I last saw her alive on July 26 1945

Immediate cause of death	DURATION
Carcinoma of Rt Breast with Metastasis	5 yrs
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Operation ago yrs 15
1943. D&C S. White Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: Reed C Van Hatta M. D.
Address: Washington 18 D.C. Date signed: July 27 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

17210

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos., 19 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 9 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3145 38th St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HARRY A. SINGER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 12, 1887

8. AGE:

Years	Months	Days	If less than one day
57	7	16	hrs. min.

9. Birthplace: Clearfield, Iowa (Town, county, and state)

10. Usual occupation: Radio Technician

11. Industry or business:

FATHER — 12. Name: Louis Upton Singer

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Nellie Fidelia

15. Birthplace: Iowa

16. Informant: Decedent

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof July 29 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: L. A. Pines Co

Address: 2901-14th St. N.W. Wash., D.C.

19. July 28, 19 45 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945 at 8.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 9, 1944, to July 28 1945

and that I last saw h. him alive on July 28 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 yrs, 6 mo. 23 da.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 7/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07211

★ Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (I) (T) MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Hr. 40 minutes

Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital

How long in hospital or institution? 1 Hr. 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Berwyn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: -
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Infant Boy Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): July 27, 1945

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 40 min.

9. Birthplace: Riverdale, Maryland
(Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER
12. Name: Earl Lewis Smith
13. Birthplace: Maryland

MOTHER
14. Maiden name: Dorothy Marguerite Sines
15. Birthplace: Maryland

16. Informant: Mother- Mrs. Dorothy S. Smith

Address: Same

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28, 1945 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Bladensburg Md

18. Funeral director: E. Gaskie sons

Address: Hyattsville Md

19. July 28 19 45 (Date rec'd by registrar) James Seavey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1945 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 7:35 a.m. 1945, to July 27 9:15 a.m. 1945 and that I last saw him alive on July 27 9:15 a.m. 1945

Immediate cause of death	DURATION
a. Prematurity	
b. Premature birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L O Graham MD M. D. or other

Address: Riverdale, Md Date signed: 7-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-E)

07212

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Prince George's Gen. Hospt.

How long in hospital or institution? 4 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: District of Columbia
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5300 V St. S.E. Washington
(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME

Paul Randolph Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 8, 1930

8. AGE:

Years	Months	Days	If less than one day
15		18	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Child (school boy)

11. Industry or business: .....

FATHER
12. Name: Smith, Edwin
13. Birthplace: Chester, Pa.

MOTHER
14. Maiden name: Moore, Margy.
15. Birthplace: Forrestville, Md.

16. Informant: Smith, Mrs. Edwin (Father)
Address: 5300 V St. S.E. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/26/45 (month) (day) (year)

Cemetery or crematory: N. W. Chambers, Co

Location: 517-11-St. S.E. D.C.

18. Funeral director: N. W. Chambers, Co

Address: 517-11-St. S.E. wash. D.C.

19. 7/26 19 45 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 19 45, at 7 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 45 to July 26 19 45 and that I last saw him alive on July 25 19 45

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to Staphylococcus Septicemia Transfusion and Cerebral abscess	15 days
Due to	
Other conditions Acute Gradature nephritis (Include pregnancy within 3 months of death)	6 days

Major findings of operations: .....

Date of op. .....

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Washington 14 DC Date signed July 26 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

CERTIFICATE OF DEATH

07213

Reg. Diat. No. 234

1. PLACE OF DEATH:

County Prince George

City or town Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

5401- Auth Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Camp Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5401- Auth Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert Contie Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

8.(b) Name of husband or wife Ada M Smith

8.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) November 11, 1870

8. AGE:

Years	Months	Days	If less than one day
74	6	20	..... hrs. ..... min.

9. Birthplace Brandywine Md

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Robert Smith

13. Birthplace T. B., Md

MOTHER

14. Maiden name Louise Brooker

15. Birthplace Brandywine, Md

16. Informant Ada M Smith

Address 5401- Auth Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2- 1945 (month) (day) (year)

Cemetery or crematory St Johns Cemetery

Location Clinton Maryland R.F.D. 2

18. Funeral director Thomas F Murray

Address 2007- Nichols Ave S.E.

19. Aug 1 1945 Howard L Bond

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945 at 6.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intra Cranial hemorrhage	
Due to Cardio vascular renal disease	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner James T. Boyd M. D. or other

Address 7 Deerfield Ter Date signed 7-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19a)

CERTIFICATE OF DEATH

(17211) Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince Georges.
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 10 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 733 - Douglas st. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Owen Snyder III

3.(b) Social Security Number: x x x

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife: x x x
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 7th 1945

8. AGE: Years	Months	Days	If less than one day
0	2	13	hrs. mins.

9. Birthplace: Washington D. C.
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: George O Snyder Jr
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Shirley E. Gibson
15. Birthplace: Lynchburg, Va.

16. Informant: Geo. O. Snyder Jr.
Address: 733 - Douglas st. N. E.

17. July 21, 1945 Burial Date thereof July 21, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Congressional Cemetery.
Location: Washington D.C.

18. Funeral director: H. H. Chambers Co.
Address: Riverdale, Md.

19. July 21, 1945 James Severy
(Date rec'd by registrar) Registrar
M. Bradshaw

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 20 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 10 1945, to 7 20 1945; and that I last saw h alive on 7 20 1945.

Immediate cause of death	DURATION
a. Myocardial degeneration	
Due to: Chronic enteritis	6 wks
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B Pharr M. D. or other
Address: Laurel Md. Date signed 7-20-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

07215

★ Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince Georges

City or town Croome

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

Airport Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Croome

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Stewart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife Susie Stewart

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1, 1895

8. AGE:	Years	Months	Days	If less than one day
	50	0	22	..... hrs. ..... min.

9. Birthplace Croome, Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name William Stewart

13. Birthplace Maryland

MOTHER 14. Maiden name Mary E. Cook

15. Birthplace Maryland

16. Informant Percy Stewart

Address Croome, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-24-45 (month) (day) (year)

Cemetery or crematory St. Simons

Location Croom, Md

18. Funeral director Pickett Bros.

Address Upper Marlboro, Md

19. July 24 1945 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorhage and shock	
Due to Crushed chest	
Fractured skull	
Due to Fracture left arm	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-22-45

Where did injury occur? Croome (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where) Airport Road

Means of injury Pedestrian struck by car Was it in line of work? no

23. SIGNATURE Deputy medical Examiner James D. Boyd M. D. or other

Address Forestville Md Date signed 7-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

07216

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Prince George's General Hosp.
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 200 Rhode Island Ave NE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Strauch, Charles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife: Victoria Strauch
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 18-1898

8. AGE: Years	Months	Days	If less than one day
46	11	24	hrs. min.

9. Birthplace: Michigan (town, county, and state)
10. Usual occupation: accountant
11. Industry or business

FATHER
12. Name: Joseph Strauch
13. Birthplace: Michigan

MOTHER
14. Maiden name: Elizabeth Haberth
15. Birthplace: Michigan

16. Informant: Victoria Strauch
Address: 200 Rhode Island ave NE

17. Burial, cremation, or removal. Which?: Removal
Date thereof: July 25-45 (month) (day) (year)

Cemetery or crematory:
Location: Washington, D.C.

18. Funeral director: T. F. Costello
Address: 1722-N. Cap. St. Wash. D.C.

19. 7/25 (Date rec'd by registrar) 19 45 Amado Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 19 45 at 8 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 45 to July 25 19 45 and that I last saw h. alive on July 25 19 45

Immediate cause of death: Toxemia, Probable Septicemia — DURATION

Due to: Bacterial Endocarditis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Ormsan M.D. or other
Address: Prince Geo General Date signed 7-25-45

M

I

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1910)

CERTIFICATE OF DEATH

07217

Reg. Dist. No. 202

1. PLACE OF DEATH:

County Prince George

City or town Upper Marlboro (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Crane Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Prince George

City or town Upper Marlboro (If outside city or town limits, write RURAL and give nearest town)

Street No. Crane Highway (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jessie Frances Suit

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife George Suit

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) August 25, 1862

8. AGE: Years 82 Months 10 Days 21 If less than one day ... hrs. ... min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Unknown

13. Birthplace Washington DC

MOTHER 14. Maiden name Unknown

15. Birthplace Washington DC

16. Informant Mrs Guy Cole

Address Upper Marlboro Md

17. Removal Date thereof July 16 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Joseph F Birch Funeral Par.

Location 3034 M St N W Wash DC

18. Funeral director Jos F Birch's Sons

Address 3034 M St N W Wash DC

19. July 16 1945 (Date rec'd by registrar) R. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19......, to ....19......

and that I last saw h...... alive on ....19......

Immediate cause of death Congestive heart failure

Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy medical Examiner

23. SIGNATURE James I. Boyd M.D. or other

Address Forestville Md Date signed 7-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

07218

CERTIFICATE OF DEATH

★ Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges Co
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
4200 Farragut st
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4200 Farragut st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lemuel E. Tait

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elizabeth Tait
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 16, 1879

8. AGE: Years	Months	Days	If less than one day
65 years			..... hrs. ..... min.

9. Birthplace: Washington D. C. (town, county, and state)
10. Usual occupation: Retired U. S. Government
11. Industry or business: Contact represenative

FATHER
12. Name: George T. Tait
13. Birthplace: Washington D. C.

MOTHER
14. Maiden name: Ann Barnes
15. Birthplace: Washington D. C.

16. Informant: Elizabeth Tait
Address: Hyattsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26, 1945 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Arlington Virginia

18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland

19. July 24 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1945 at 7.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to July 25 1945 and that I last saw him alive on July 25 1945

Immediate cause of death	DURATION
Cardiac failure	1 hrs
Due to: Arteriosclerosis	3 yrs
Due to:	
Other conditions: Diabetes, Nephritis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Joseph V. Baltimore M. D. or other
Address: Hyattsville Md Date signed 7-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 518

07219

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:
County: Prince Georges
City or town: Silesia, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Sieslia, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8800- Riverview Road S. E. Wash 20, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Albert F. Taylor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mattie May Taylor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 2nd. 1878

8. AGE: Years	Months	Days	If less than one day
67	5	22	..... hrs. ..... min.

9. Birthplace: Friendly, Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Joseph Taylor
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Thorne
15. Birthplace: Maryland

18. Informant: Mrs Mattie May Taylor
Address: 8800- Riverview Road Wash, 20 S. E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27th. 1945 (month) (day) (year)
Cemetery or crematory: St. Johns Cemetery
Location: Broad Creek, Maryland

18. Funeral director: Thomas F. Murray.
Address: 2007- Nichols Ave. S. E. Wash. D.C.

19. July 25 1945 (Date rec'd by registrar) Howard I. Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24th. 1945 at 1-P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1945 to July 24 1945 and that I last saw h... alive on July 24 1945

Immediate cause of death	DURATION
Toxemia	
Ebanation	
Due to Carcinoma of prostate	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James J. Boyd M. D. or other
Address: Forestville Md. Date signed 7/24th/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

117221

★ Reg. Dist. No. 245

VS A15 (T) (1) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Prince Georges

City or town: Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

3714 - Perry Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3714 - Perry Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frederick Herbert Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emilie Thomas

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Aug 12, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	15	...hrs. ...min.

9. Birthplace: District of Columbia (Town, county, and state)

10. Usual occupation: Retired Construction Superintendent

11. Industry or business: Building

FATHER — 12. Name: Joseph B. Thomas

FATHER — 13. Birthplace: District of Columbia

MOTHER — 14. Maiden name: Alice Fawcett

MOTHER — 15. Birthplace: Maryland

18. Informant: Reginald C. Thomas

Address: 430 - 4½ St. S.E., Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30 - 45 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Wash. D.C.

18. Funeral director: L. H. Hines Co.

Address: 2901 - 14th St. N.W. Wash., D.C.

19. July 27 19 45 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 45 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Acute Congestive	
heart failure	
Due to: Cardiosclerosis	
secondary	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Deputy medical Examiner

23. SIGNATURE: James M. Ford M. D. or Other

Address: 7 Rockville Md. Date signed: 7-27-45

Evidence for change of age is shown on FILM ... G 9.6 JUL 17 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

07221

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 hrs.
Hospital, institution, or street address where death occurred: Prince George's Gen. Hospt.
How long in hospital or institution? 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince Geo. Co.
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8351 old Bladensburg Rd. S.E. Washington, D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thorne Mr. Millard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Thorne, Mrs. Margaret
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Feb. 10-18-64 1874

8. AGE: Years	Months	Days	If less than one day
71 69-	4	7	...hrs. ...min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Judge of Orphans Court
11. Industry or business:
12. Name of father: Thorne, Mr. Wm. Thomas
13. Birthplace of father: Md.
14. Maiden name of mother: Watson, Mrs. Agnes
15. Birthplace of mother: Scotland.
16. Informant: Daniel R. Thorne (Son)
Address: 6711 Allentown Rd. Wash. 20, D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 5 1945 (month) (day) (year)
Cemetery or crematory: St Johns
Location: Broad Creek, Maryland
18. Funeral director: Thomas F. Murray
Address: 2007 Nichols Ave S.E.
19. 7/4 1945 (Date rec'd by registrar) Amanda Denney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1945, at 2:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945, to July 3 1945
and that I last saw h... alive on July 2 1945

	DURATION
Immediate cause of death: Mesenteric Thrombosis	3 days
Due to: General Arteriosclerosis and Chronic Nephritis	indefinite
Due to: Myocardiolysis	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: Massive mesenteric Thrombosis Date of op. 7/2/45
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —> no
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul C. Von Hatten M. D. or other
Address: Washington 19 DC Date signed: 7/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

07222

CERTIFICATE OF DEATH

★ Reg. Dist. No. 239

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County P.G.
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Third Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Eliza Tolson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Wid. married

6.(b) Name of husband or wife Edward S. Tolson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1863

8. AGE: Years	Months	Days	If less than one day
82	5	19	..... hrs. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name David H. Stonebraker
13. Birthplace Balto. Md.
MOTHER 14. Maiden name Elizabeth Mckenrick
15. Birthplace Md.
16. Informant Edward S. Tolson
Address Laurel Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 19 1945 (month) (day) (year)
Cemetery or crematory Laurel Park
Location Baltimore, Md.
18. Funeral director W. H. Hall & Son
Address Laurel Md.
19 July 19 19 45 M. Brashears Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 19 45, at 4:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-18 19 44, to 7-17 19 45
and that I last saw her alive on 7-17 19 45

Immediate cause of death	DURATION
Arteriosclerosis	2
Chronic Myocarditis	1
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE N. B. Sherwood M. D. or other
Address Laurel Date signed 7/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93(a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 17223239

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Prince Georges

City or town Bowie - Town Bowie Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 27 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr Georges

City or town Bowie, Town-Town Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frances Quinlan Tompkins

3. (b) Social Security Number 218-01-0816

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Tasy Tiddon Thompson Tompkins

6(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): June 30 1886

8. AGE: Years: 59 Months: Days: 13 If less than one day: hrs. min.

9. Birthplace: Small, Spotsylvania Co. Va. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Feed.

FATHER

12. Name: Francis Humphrin.

13. Birthplace: Carling Co Va.

MOTHER

14. Maiden name: Alfa Stewart

15. Birthplace: Small, Spotsylvania Co, Va.

16. Informant: Mrs Tasy Tompkins

Address: Bowie Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 16, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: P.G. Co. Md

18. Funeral director: G. W. Hill & Sons Lanham

Address: Laurel Md

19. July 15 1945 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1945, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1940 to July 13 1945, and that I last saw h[illegible] alive on July 13 1945.

Immediate cause of death	DURATION
Acute myocarditis	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S McCreary M.D. M. D. or other

Address Laurel Md Date signed 7/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07224

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 4 mos., 21 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 yrs., 4 mos., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1240 Raum Street S. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: NAYLOR CHESTER VEACH

3. (b) Social Security Number: 578-01-6524

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pearl E. Veach

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): March 27, 1909

8. AGE: Years	Months	Days	If less than one day
36	4	3	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER
12. Name: Cary W. Veach
13. Birthplace: Warren Co., Virginia

MOTHER
14. Maiden name: Rosa Mae Naylor
15. Birthplace: Warren Co., Virginia

16. Informant: Decedent
Address:

17. (Burial, cremation, or removal. Which?) Removal Date thereof: July 30, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: The S.H. Hines Co.

Address: 2901 — 14th St. N.W.

19. (Date rec'd by registrar) July 30 19 45 Registrar: Rowland S. Phillips

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 30 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 9 1942 to JULY 30 1945, and that I last saw h...alive on JULY 30 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	3 yrs 4 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 7/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486)

CERTIFICATE OF DEATH

11725

★ Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 823 - Jefferson St, N.W. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Sarah Campbell Wayland

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: J. Edgar Wayland

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1872

8. AGE:

Years	Months	Days	If less than one day
73	2	28	hrs. min.

9. Birthplace: Mt. Jackson, Virginia (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Robert H Campbell

13. Birthplace: Va.

MOTHER — 14. Maiden name: Isabel Stewart

15. Birthplace: Va.

16. Informant: Mrs. R. L. Nalls

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 9, 1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Washington D.C.

18. Funeral director: Deal Funeral Home

Address: 4812 Ga Ave. NW

19. 7/9 (Date rec'd by registrar) 1945 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-9 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-28 1945, to 7-9 1945, and that I last saw h[illegible] alive on 7-9 1945

Immediate cause of death: Carcinoma of uterus with extension thru pelvis — DURATION: 4 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L C Bruner M D (M. D., or other)

Address: Mt. Rainier Md Date signed: 7-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

17226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo., 2 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 1 mo., 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 608 - E. Capitol St.
(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: WILLIS, LEE H.

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 27, 1880

8. AGE: Years	Months	Days	If less than one day
64	11	25	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Bartender

11. Industry or business:

FATHER — 12. Name: John M. Willis

13. Birthplace: Remington, Virginia

MOTHER — 14. Maiden name: Callie Melvin

15. Birthplace: Washington, D. C.

16. Informant: Decedent

Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: July 24/1945 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: W W Chambers Co.

Address: 617-11 St SE.

19. July 22 19 45 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22, 19 45, at 1220 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20, 19 45, to July 22, 19 45 and that I last saw h[illegible]ive on July 22, 19 45

Immediate cause of death	DURATION
Tuberculosis pulmonary	6 weeks
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Bilateral cavernous and fibrocaseous nodose pulmonary tuberculosis.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. (M. D. or other)
Address: Glenn Dale, Md. Date signed: 7/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

11-7227

Reg. Dist. No. 232

1. PLACE OF DEATH:
County Prince Georges
City or town Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland, County Prince Georges
City or town Upper Marlboro.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Washington Wilson, Sr.,

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife Nelle F. Flegal
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 5 - 1875.

8. AGE: Years	Months	Days	If less than one day
69	7	1	hrs. min.

9. Birthplace Upper Marlboro, Md.
(Town, county, and state)
10. Usual occupation Carpenter.
11. Industry or business

FATHER 12. Name George W. Wilson
13. Birthplace Md.

MOTHER 14. Maiden name Anna Eloise Carpenter
15. Birthplace Clifton Forge, Va.

16. Informant Mrs. Geo. W. Wilson
Address Upper Marlboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-45. (month) (day) (year)
Cemetery or crematory Family
Location Upper Marlboro, Md.

18. Funeral director Ritchie Brothers
Address Upper Marlboro, Md.

19. July 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1945 to July 6 1945
and that I last saw him alive on July 6 1945

Immediate cause of death	DURATION
Carcinoma of Stomach -	
Due to with Metastes	
to Liver.	1 year
Due to	
Other conditions Hemidary Anemia	6 months

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. —
Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James F. Fascer, M. D. or other
Address Upper Marlboro, Md. Date signed 7-7-45